
PATIENT INFORMATION Lydia M. Pak, DDS• Pediatric Dentistry

/ /

Patient Name: _____ Age _____ Sex _____ Birth date: _____
Address: _____ City: _____ Zip: _____ Phone: _____
School: _____ Grade: _____
Head of Household: _____ Bus. Phone: _____
Emergency Contact : Name/ Relationship _____ / _____ Phone: _____
Name of Physician: _____ Phone: _____
Physician's Address: _____ Date of Last Physical: _____ / _____

I. MEDICAL HISTORY

- | | <u>Yes</u> | <u>No</u> |
|--|------------|-----------|
| 1. How is the general health of your child? _____ | | |
| 2. Has your child experienced any serious illness (rheumatic fever, diabetes, hepatitis, kidney disease, jaundice, tuberculosis, anemia)? _____ | [] | [] |
| 3. Does your child have any unusual physical condition (heart defect, developmental defect, or neuromuscular defect such as cerebral palsy)? _____ | [] | [] |
| 4. Does your child have asthma or any lung conditions which cause breathing difficulty?
_____ | [] | [] |
| 5. Has your child ever been hospitalized? Explain why and when. _____ | [] | [] |
| 6. Does your child bruise easily or bleed unusually long after a cut? _____ | [] | [] |
| 7. Does your child have allergies (latex, food, or other)? _____ | [] | [] |
| 8. Has your child ever experienced any unusual reaction to any drug or any anesthetics?
_____ | [] | [] |
| 9. Is your child currently taking any medication or receiving any drug therapy? _____ | [] | [] |
| 10. How would you describe your child's general behavior? _____ | | |

II. DENTAL HISTORY

1. What is the chief reason for this visit? _____
2. When was your child's last dental examination? _____
3. Has your child received dental care before? If yes, briefly describe the age, the behavior and the treatment received. _____
4. Has your child experienced any major injury to the face or teeth? If yes, explain how and when. _____
5. Does your child have any oral habit such as finger sucking and pacifier use? _____

III. DIET/ORAL HYGIENE

1. What are his/her usual snacks and how many times a day? _____
2. Who brushes the child's teeth and how many times a day? _____

Person Responsible for Payment

Name: _____ Relationship: _____ DOB: _____

Social Security #: _____ Driver's License #: _____

DENTAL INSURANCE INFORMATION			
<u>Dental Insurance Primary Carrier</u>		<u>Dental Insurance Secondary Carrier</u>	
Insured's Name:	Social Security #:	Insured's Name:	Social Security #:
_____	_____	_____	_____
Insurance Company:		Insurance Company:	
_____		_____	
Address:		Address:	
_____		_____	
Group #:	ID #:	DOB:	
_____	_____	_____	_____
Insured's Employer:		Insured's Employer:	
_____		_____	

AUTHORIZATION AND RELEASE

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, billing and processing of insurance for benefits to which my child is entitled. If my child ever has any changes in his/her health, or if his/her medicines change, I will inform the Doctor of Dentistry at the next appointment without fail. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care, to third party payers and/or other health practitioners. I authorize my insurance company to pay directly to the dental office the benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my child's behalf.

 X
Signature of parent/guardian Date Dentist's signature Date

Since the office has other patients urgently seeking dental care, we strongly encourage that you keep your appointment. I understand there will be \$50 broken appointment charge if you fail to give 24 hr advance notice. Initials: _____

MEDICAL HISTORY UPDATE			
Date	Addition/Date of last physical evaluation	Parent Signature	Dr. Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____